PSYCHIATRIC SECURITY REVIEW BOARD
Conditional Release Application, Pursuant to C.G.S. Section 17a-588

Application filed by:

- ☐ Superintendent of Connecticut Valley Hospital
- ☐ Commissioner of the Department of Mental Retardation
- ☐ Acquittee
- ☐ Acquittee's Legal Representative
- ☐ Other (please specify)

Accompanying this Conditional Release Application, please submit a report to the PSRB that includes, but is not limited to, the information listed below.

a. A summary of the acquittee's current treatment, treatment progress and the clinical rationale supporting this Conditional Release Application
b. A risk assessment including risk and protective factors and the risk management plan
c. Conditional Release Application Community Provider Approval Form(s) (if applicable)

A. ACQUITTEE INFORMATION

Name: **Date of Birth:**

Gender: **PSRB ID No.:**

1. Acquittee Citizenship

Is the acquittee a United States citizen? ☐ Yes ☐ No

Does the acquittee have a passport? ☐ Yes ☐ No

If *yes*, who will hold the passport while on conditional release?

If acquittee ***is not*** a United States citizen, answer the following questions:

a. Of what country is the acquittee a citizen?

b. What is the acquittee's immigration status? (Attach appropriate documentation)

- ☐ Lawful Permanent Resident (has a "green card")
- ☐ Resident alien
- ☐ In the United States on a visa
  - Type of visa:
  - Expiration date:
- ☐ Undocumented ("illegal") alien
- ☐ Other (please explain below)

c. Is the acquittee legally able to obtain employment? ☐ Yes ☐ No

If *yes,* please attach verifying documentation.

2. DNA Registry

a. Has the acquittee been asked to provide a DNA sample pursuant to Connecticut General Statutes Section 54-102g? ☐ Yes ☐ No

If *no,* explain.

b. Has a DNA sample been collected? ☐ Yes ☐ No

If *no,* explain.

c. Is the acquittee required to register as a sex offender, pursuant to Connecticut General Statutes Section 54-250 through 54-261? ☐ Yes ☐ No

If *no,* explain.

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3. Court Actions or Orders, Detainers, Restrictions

a. Currently, are there any pending civil or criminal court actions or proceedings? ☐ Yes ☐ No

If *yes,* please describe.

b. Currently, are there any civil or criminal court orders or detainers, FBI or Secret Service detainers or other restrictions or notification requirements in effect? ☐ Yes ☐ No

If *yes,* please describe.

c. Currently, are there any court restraining orders in effect regarding the acquittee? ☐ Yes ☐ No

If *yes,* please describe.

d. Currently, is the acquittee on probation as a result of other criminal convictions? ☐ Yes ☐ No

If *yes,* attach copy of the Conditions of Probation Order.

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4. Conservator (attach appropriate documentation)

a. Does the acquittee have a **Conservator of Estate**? ☐ Yes ☐ No

Probate Court:
Conservator Name:
Address:
Telephone #:
Fax #:

b. Does the acquittee have a **Conservator of Person**? ☐ Yes ☐ No

Probate Court:
Conservator Name:
Address:
Telephone #:
Fax #:

c. Does the acquittee have a **Conservator of Medical Care (or Treatment)**? ☐ Yes ☐ No

Probate Court:
Conservator Name:
Address:
Telephone #:

Fax #:

5. Family and Marital Status

a. What is the acquittee's marital/relationship status? (Check all items that apply)

- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Involved in a relationship with a significant other

b. Does the acquittee have children who are under 18 years of age? ☐ Yes ☐ No

If *yes,* please answer the following questions.

(1) Are there any current court orders regarding the acquittee's parental rights, custody, support, visitation, and/or contact with the these children? ☐ Yes ☐ No

If *yes,* please attach a copy of the relevant order(s).

(2) Is the Connecticut Department of Children and Families (DCF) involved? ☐ Yes ☐ No

If *yes,* please provide the following information.

Name of DCF Worker:
Address:
Telephone #:
Fax #:

B. CONDITIONAL RELEASE SUPERVISION

1. Conditional Release Supervisor

Agency Name (if applicable):

Agency Executive Director (if applicable):

Name of Conditional Release Supervisor:
Address:
Telephone #:
Fax #:
Pager/Cell Phone #:

2. Conditional Release Supervisor will monitor the Conditional Release and perform the following services at the indicated frequency.

Services to be provided (check all that apply): Frequency

- ☐ Supervision meetings with acquittee
- ☐ Supervision telephone calls
- ☐ Visits to acquittee's residence
- ☐ Individual therapy
- ☐ Supportive counseling
- ☐ Group therapy

- ☐ Contacting all other service providers
- ☐ Verification of attendance at community substance abuse support meetings
- ☐ Random drug/alcohol screenings
- ☐ Contact with acquittee's employer
- ☐ Other services (specify below)

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3. Office of Adult Probation Supervision

Is supervision by the Office of Adult Probation recommended? ☐ Yes ☐ No

a. If yes, what are the recommendations for supervision?

b. Has the Office of Adult Probation been contacted and informed of the recommendations for supervision? ☐ Yes ☐ No

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C. COMMUNITY PROVIDER TRAINING AND INVOLVEMENT

1. Has the proposed Conditional Release Supervisor completed formal PSRB training? ☐ Yes ☐ No

   If *yes,* date:

2. Have other involved community providers, including relevant supervisory staff, completed formal PSRB training? ☐ Yes ☐ No

   If *yes,* please indicate:

   Staff Name/Agency Date

   If *no,* when will training be completed?

   Staff Name/Agency Date

3. Have the Conditional Release Supervisor and relevant community providers been orientated by the treatment team regarding their roles and responsibilities? ☐ Yes ☐ No

4. Have the Conditional Release Supervisor and relevant community providers been given a current copy of the *PSRB Acquittee Information Packet*? ☐ Yes ☐ No

5. Have the Conditional Release Supervisor and relevant community providers attended the acquittee's hospital treatment planning meetings and been actively involved in planning this conditional release? ☐ Yes ☐ No

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D. CONDITIONAL RELEASE PLAN

1. Residential Plan

a. Where will the acquittee be living? (Check all that apply)

- ☐ Acquittee's residence
- ☐ Family's residence

Name Relationship

- ☐ DMHAS or DMR residential program
- ☐ Acquittee's residence with support from a DMHAS or DMR residential program
- ☐ Other mental health/human services agency residential program
- ☐ Other (please explain below)

Acquittee's address:

Acquittee's telephone number (if available):

b. If proposed housing is a community-based residential program of DMHAS, DMR, or other mental health/human services agency, please complete the following.

Type of residential program:
Type of license from DPH:
Agency:
Executive Director:
Program Name:
Contact Person:
Address:
Telephone #:
Fax #:

Residential Program Staff Coverage/Availability

- ☐ On-site 24-hours per day, 7 days per week
- ☐ On-site during work week, plus 24-hour beeper/telephone coverage
- ☐ Off-site during work week, plus 24-hour beeper/telephone coverage
- ☐ Off-site beeper/telephone coverage 24 hours per day, 7 days per week
- ☐ Other (please describe below)

Residential Program Services

- ☐ Budgeting assistance
- ☐ Directly observe medication being taken
- ☐ Monitor medications by counts, medication boxes, etc.
- ☐ Individual counseling
- ☐ Group counseling
- ☐ Drug/alcohol counseling
- ☐ Random drug/alcohol screening
- ☐ Vocational rehabilitation program
- ☐ Daily living skills training/assistance
- ☐ Medical assistance
- ☐ House/residents/support group
- ☐ Structured recreation
- ☐ Visit acquittee's residence
- ☐ Congregate meals
- ☐ Other (please describe below)

c. Is there a recommendation for a curfew, sign-in/sign-out log, or other form of residential monitoring? ☐ Yes ☐ No ☐ N/A

If *yes*, please describe:

d. Required staff visits to the acquittee's residence other than by the Conditional Release Supervisor for the purposes of monitoring and supervision. ☐ N/A

Frequency:
Contact Person:
Agency:
Address:
Telephone #:
Fax #:

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2. Activities

Complete all applicable sections listed below detailing activities in which the acquittee will be participating.

a. Community Providers (list all) ☐ N/A

(1) Agency/Practitioner:
Executive Director:
Address:
Telephone #:
Fax #:

(2) Agency/Practitioner:
Executive Director:
Address:
Telephone #:
Fax #:

(3) Agency/Practitioner:
Executive Director:
Address:
Telephone #:
Fax #:

(4) Agency/Practitioner:
Executive Director:
Address:
Telephone #:
Fax #:

(5) Agency/Practitioner:
Executive Director:
Address:
Telephone #:
Fax #:

(6) Agency/Practitioner:
Executive Director:
Address:
Telephone #:
Fax #:

b. Treatment Activities ☐ **N/A**

Agency	Contact Person	Activity	Frequency

c. Couples/Family Therapy ☐ **N/A**

Agency	Contact Person	Frequency

d. Psychosocial/Educational/Other Community Support Activities ☐ **N/A**

Agency	Contact Person	Activity	Frequency

e. Pre-Employment Vocational Services ☐ **N/A**

Agency	Contact Person	Activity	Frequency

f. Employment ☐ **N/A**

(1) Type of Employment (Check all that apply)
- ☐ Volunteer
- ☐ Sheltered Workshop
- ☐ Competitive

Employer(s) Name(s):
Address(es):
Telephone #:

(2) Based on clinical considerations, how many hours may the acquittee work per week?

(3) Have supervisor(s) and relevant managers at the proposed work site been oriented? ☐ Yes ☐ No

If *yes*, by whom:

If *no*, when and by whom will this be done?

(4) Will vocational counseling/other vocational services be provided to the acquittee while employed? ☐ Yes ☐ No

If *yes*, please specify:

Agency:
Executive Director:
Contact Person(s):

Address:
Telephone #:
Fax #:

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3. Monitoring of Medication Compliance ☐ **N/A**

Method of Monitoring:
Frequency:
Agency:
Contact Person:
Address:
Telephone #:
Fax #:

Method of Monitoring:
Frequency:
Agency:
Contact Person:
Address:
Telephone #:
Fax #:

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4. Drug and Alcohol Screenings ☐ **N/A**

Type:
Frequency:
Agency:
Contact Person:
Address:
Telephone #:
Fax #:

Type:
Frequency:
Agency:
Contact Person:
Address:
Telephone #:
Fax #:

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5. Health Care Providers

Primary Medical Provider:
Address:
Telephone #:
Fax #:

Has provider been informed of acquittee's PSRB status? ☐ Yes ☐ No

Major/Relevant Medical Conditions

Medical Condition:
Medical Provider:
Address:
Telephone #:
Fax #:

Has provider been informed of acquittee's PSRB status? ☐ Yes ☐ No

Medical Condition:
Medical Provider:
Address:
Telephone #:
Fax #:

Has provider been informed of acquittee's PSRB status? ☐ Yes ☐ No

Medical Condition:
Medical Provider:
Address:
Telephone #:
Fax #:

Has provider been informed of acquittee's PSRB status? ☐ Yes ☐ No

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6. Social Contacts

a. List below the name and relationship to the acquittee of each friend, family member, or significant other with whom the acquittee will or may maintain **regular** contact.

Full Name Relationship

b. Do any of the friends, family members, or significant others listed above have **recent** histories of substance abuse? ☐ Yes ☐ No

If *yes,* please describe.

c. Do any of the friends, family members, or significant others listed above have histories of criminal activities, arrests, and/or convictions? ☐ Yes ☐ No

If *yes,* please describe.

d. Do the treatment team/community providers recommend any specific conditions (e.g., supervision, couples/family therapy, family support/education) for contact with any of the friends, family members, or significant others listed above? ☐ Yes ☐ No

If *yes,* please describe.

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7. Limited or Prohibited Contacts

a. May the acquittee have contact with the victim(s) of his/her crime? ☐ Yes ☐ No ☐ N/A

If *yes,* under what circumstances/limitations?

b. Will the acquittee have contact or visits with his/her own children under 18 years of age? ☐ Yes ☐ No ☐ N/A

If *yes,* what are the recommendations regarding contact or visits?

c. Will the acquittee have ongoing contact with children under 18 years of age known to the acquittee? ☐ Yes ☐ No ☐ N/A

If *yes,* what are the recommendations regarding contact or visits?

If *yes,* has the parent(s) or legal guardian(s) of the children under 18 years of age given their permission for contact with the acquittee? ☐ Yes ☐ No

If *no,* please explain.

d. Should there be limitations on contact with other children under 18 years of age? ☐ Yes ☐ No

If *yes,* please explain.

e. Are there other specific persons with whom contact by the acquittee should be limited or prohibited? ☐ Yes ☐ No

If *yes,* please explain.

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8. Computer, Internet and E-Mail Access

a. The acquittee will have access to:

Computer	☐ Yes	☐ No
Internet	☐ Yes	☐ No
E-mail	☐ Yes	☐ No

b. Are there any contraindications/risk management issues for access? ☐ Yes ☐ No

If *yes,* please describe the recommended restrictions.

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9. Travel and Transportation

a. Who will provide transportation for the acquittee? (Check all that apply)

- ☐ Community agency
  Name(s) of agency:
- ☐ Family/Significant other
  Name(s) of Family/Significant Other:
- ☐ Public transportation in own custody
- ☐ Acquittee's own vehicle (attach a copy of registration and proof of insurance)
- ☐ Other (please describe)

b. Are there limitations for where the acquittee may travel within the State of Connecticut? (Include towns or locations prohibited) ☐ Yes ☐ No

If *yes,* please describe.

c. May the acquittee travel and participate in leisure/recreation activities in his/her own custody? ☐ Yes ☐ No

(1) Describe any time limitations for travel during leisure time in his/her own custody.

(2) Describe any geographic limitations for travel during leisure time in his/her own custody.

d. Recommendations Regarding Motor Vehicles

(1) Is it recommended that an acquittee be permitted to drive a motor vehicle? ☐ Yes ☐ No

If yes, describe the recommended conditions or restrictions and attach a copy of the driver's license.

May the acquittee have passengers? ☐ Yes ☐ No

If yes, describe any recommended conditions or restrictions.

(2) May the acquittee be a passenger in a motor vehicle driven by someone other than a community provider? ☐ Yes ☐ No

If yes, describe any recommended conditions or restrictions.

e. Proposed Out-Of-State Travel

May the acquittee travel out of the State of Connecticut for day trips? ☐ Yes ☐ No

If yes, describe.

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10. Six-Month Reporter

Agency:
Executive Director (if applicable):
Name of Designated Reporter:
Address:
Telephone #:
Fax #:
Email Address:

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11. Other Conditions

Are there any other recommendations for this conditional release? ☐ Yes ☐ No

If *yes,* please explain.

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12. Finances

a. How will the costs of the proposed services and living expenses be covered?

(Check all that apply)	Type (If applicable)	Amount
☐ Savings		
☐ Insurance		
☐ Government entitlements		
☐ Employment		
☐ DMHAS		
☐ DMR		
☐ Family		
☐ Other (specify below)		

b. Please list any housing costs (rent, mortgage, etc.) to be paid by the acquittee.

c. Please list any costs for treatment or support services to be paid by the acquittee.

d. Please describe any fiscal concerns related to this conditional release and how they will be addressed.

e. Does the acquittee require budget assistance? ☐ Yes ☐ No

If *yes*, who will provide that service?

f. Does the acquittee require third party payeeship? ☐ Yes ☐ No

If *yes*, who will provide that service?
Provider:
Contact Person (if other than provider):
Address:
Telephone #:
Fax #:

Conditional Release Application Signatures (For application filed by CVH)

1. Conditional Release Application was prepared by:

_____ Date_____

2. Conditional Release Application was reviewed and approved by:

_____ Date_____
CVH Attending Psychiatrist

_____ Date_____
Consulting Forensic Psychiatrist, DMHAS

_____ Date_____
CVH Superintendent/Designee

Conditional Release Application Signatures (For application filed by other agency/person)

Conditional Release Application was prepared by:

_____ Date_____
Name

_____
Printed name of signatory

_____
Agency, if applicable

EMERGENCY PLAN FOR ACQUITTEES ON CONDITIONAL RELEASE*

Acquittee's Name:

Address:

Insurance Provider:

Policy #: Group #:

Conditional Release Supervisor:

Agency:

Telephone #: Fax #:

Beeper #: Cell #:

PHONE NUMBERS FOR REQUIRED NOTIFICATIONS

1. Psychiatric Security Review Board (PSRB): Use the beeper after hours **OR** if you only reach voicemail - Leave your name, telephone number, acquittee's name and nature of the situation. If you get no response within 15 minutes, beep again.
   Telephone #: (860) 566-1441 Fax #: (860) 566-1425
   Beeper #: (800) 362-7243 PIN# "112233" or "PSRB"
2. DMHAS Conditional Release Service Unit:
   Erin Leavitt-Smith, L.P.C.
   Telephone #: (860) 262-5879 Fax #: (860) 262-5841
   Beeper #: (800) 946-4645 PIN# 860 820 8534
3. Other Emergency Contacts (e.g., agency administrators, acquittee's family members, etc.)

Name: Telephone #:

Name: Telephone #:

Name: Telephone #:

Name: Telephone #:

VOLUNTARY INPATIENT TREATMENT OPTIONS

☐	Respite Bed	Agency:	Telephone #:
☐	Crisis Bed	Agency:	Telephone #:
☐	Other	Agency:	Telephone #:
☐	Community Hospital	Name:	Telephone #:
☐	DMHAS Funded Inpatient Service	Name:	Telephone #:
☐	Connecticut Valley Hospital		

Transportation Options for Voluntary Placement:

- Community staff may transport if transport determined safe
- By ambulance, arranged by community

INVOLUNTARY HOSPITALIZATION BY ORDER OF REVOCATION BY THE PSRB

Admission to the Dutcher Service or the maximum-security Whiting Service of the Whiting Forensic Division of Connecticut Valley Hospital is to be determined by the PSRB.

Transportation Options for Revocation:

- Community staff may transport if determined safe
- By ambulance, arranged by community
- By DMHAS Public Safety (by PSRB Order)
- By Connecticut State Police - arranged by PSRB or DMHAS Public Safety (by PSRB Order)

***Conditional Release Supervisor to review and update at every All Treaters Meeting.**

Copies to be filed with:

1. Acquittee
2. PSRB
3. Conditional Release Supervisor
4. LMHA Mobile Crisis
5. DMHAS Conditional Release Service Unit
6. Residential Program
7. Office of Adult Probation
8. Others (please list below)